SUPREME COURT OF THE STATE OF NEW YORK
COUNTY OF SUFFOLK: PART 48

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IN RE: OPIOID LITIGATION

INDEX NO.:400000/2017

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July 12, 2021
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MINUTES OF TRIAL

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Supreme Court Justice

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SR. COURT REPORTER

THE CLERK: Supreme Court is now in session. The Honorable Jerry Garguilo presiding.

Good morning, your Honor.

THE COURT: Good morning everybody. Good morning. Please be seated.

THE CLERK: This is continuing trial In Re: Opioid Litigation. Jury is not present.

So yesterday I'm looking at my email 5 p.m. goes by, nothing; 6 p.m. goes by, nothing; 7 p.m., I'm doing good. 8 p.m. I'm watching Shark Week, that was almost appro po. Nine o'clock, now I'm giving one of these, right. Then 9:20, boom, the phone goes off. And you folks, some of you continue to submit after the midnight hour.

I need some help. I spent sometime this weekend, for instance, on the Day, D-A-Y, transcripts, and we also spent sometime on the one, actually, I think it's Pyfer.

Oh, Brennan, excuse me. I did Day myself, of course, and I asked for the assistance of my law secretary, Miss Galteri, in connection with Brennan.

I'm aware of the issue that was brought up by Mr. Oleske on Friday. I'm trying to look for a method that makes it manageable for the Court to inform you as to what the Court's rulings are on the contested portions of each deposition.

And, Mr. Oleske, as I understand it, the only assistance, as far as your research in the case, the only assistance, and if I'm wrong you'll tell me, that the Court can reach out for is with a "judicial employee."

MR. OLESKE: Yes, your Honor. Including the law department. So I think --

THE COURT: According to research, I can access the law department?

MR. OLESKE: The direction from the case law is, in fact, that's what a reverse saying, the Court should have relied on the law department.

THE COURT: It should?

MR. OLESKE: Yes.

THE COURT: So, in other words, if I engage the assistance of the law department, we're okay.

MR. OLESKE: That's what the case law suggests, your Honor, yes.

THE COURT: All of you feel the same way? I don't see anybody saying no.

MR. PRESNAL: Well, Judge --

THE COURT: Understand something, nothing leaves my desk. Nothing leaves my desk without an intensely careful review so...

MR. PRESNAL: Judge, we did a little bit of research over the weekend, and I do think that you could appoint referees to hear and report on these issues, which is what I think you have in mind. In other words, not to make direct rulings, but to make recommendations to you.

We're still discussing that issue with the Defendants, and we're not all on the same page, although I do think that we, in general terms, see it the same way.

THE COURT: If by the end of the day you can tell me if there's any consensus, of course, I'll hear it.

MR. PRESNAL: There may be some

procedural requirements of doing it via the hear and report method that have to be done, but that seems to be what the options --

THE COURT: You mention job title of people in the law department, the court attorney referee, that's their actual job title.

Okay, next step. I spent some time reviewing the past short form orders of this Court in connection with many of the issues that I anticipate hearing this morning.

Oh, by the way, does anybody know what July 17th is -- excuse me, June 17th is? I think it's the anniversary, I think it's the date that I got the assignment from the coordinating panel. I'll serve cupcakes, something.

Now, go back to June 18th, 2018, motion sequence 001 through 0019, which was originally -- which was -- it was an all-encompassing motion to dismiss. The part and parcel of it was Endo's petition to dismiss for referencing the AOD. As you know, that motion was denied.

At page 16 in this Court's short form order I noted the following -- and, by the way, I raise this because it was also raised in the motions in limine that were submitted prior to the commencement of trial.

At page -- again, at page 16, Endo's argument pursuant to CPLR 3211(a)(5) that the Plaintiffs' claims against it are barred by an assurance of discontinuance executed on March 16th -- excuse me -- March 2016 concerning its marketing Opana ER, its branded version of the semi-synthetic opioid analgesic Oxymorphone, is rejected.

On page 17 the Court goes on to note: In addition, the assurance states that nothing contained herein shall be construed to deprive any member or other person or entity of any private right under law or equity, and that it does not limit in any way the Attorney General's power to take actions against Endo for either noncompliance with its terms or noncompliance with any applicable order as to "with respect to any matters that are not part of the covered

conduct." We do know, of course, the subject matter of the AOD was Opana, and there was again a cutoff date of 2016.

The Court further notes on the page 18: Moreover, the March -- moreover, the March 2016 assurance of discontinuance does not immunize Endo from civil actions for subsequent fraudulent activities within New York or bar the counties from bringing law or equity claims against it for practices within their respective jurisdictions.

Now, keep in mind, that motion way back when, that's sequence 001, did not involve the State. It was -- at that point the only Plaintiffs participating were all the Counties.

At motion sequence 064, the Court made additional findings, again, as concerns the AOD issues, at page 3: In addition, the assurance of discontinuance states that, again, nothing contained herein shall be construed to deprive any member or person or entity of any private right under law or equity. Again, that was, of course, noted in

the early decision. And it does not limit in any way the Attorney General's powers to take actions against the moving Defendants for either noncompliance with its terms or noncompliance with any of the applicable law.

Then it notes: With respect to any matters that are not part of the covered conduct, significantly, the moving Defendants neither admitted or denied the Attorney General's various findings of unlawful practices, statements or omissions under the General Business Law 349 and 350 regarding the marketing of Opana.

On the same page it notes: The March 2016 assurance of discontinuance does not bar the various claims asserted against the moving Defendants by the Attorney General in the instant action. While the assurance of discontinuance is an enforceable contract between the Attorney General and the moving Defendants, the purpose of such agreement was to resolve, without formal litigation, the claims that the moving Defendants engaged in deceptive consumer practices in violation of

General Business Law 349 and 350 in the marketing of Opana.

Then at motion sequence 163, once again, the AOD issue comes up, including today it's the sixth time we've heard about it.

The Court notes at page 2: The Defendants argue that they are entitled to an order barring the State of New York from predicating this public nuisance claims on evidence related to their marketing of Opana ER during the period prior to 2016 and on evidence related to their unbranded marketing of prescription opioids in general.

Again, I think there's a Stipulation in the motions in limine that the State will not go into Opana marketing prior to the effective date of the AOD.

Then this decision at page 2 goes on to note the following: In any event, the Defendants failed to demonstrate a prima facie case that the March 2016 agreement with the Attorney General extended to their marketing and supply of prescription opioids, other than Opana. Fundamental principle of

contract interpretation is that an agreement should be construed in accordance with parties' intent. The best evidence of what the parties -- the best evidence of what the parties' Agreement intends what they say in their writing. In a written agreement that is complete, clear and unambiguous on its face must be enforced according to its planned meaning.

Then at page 3: The Defendants failed to make a prima facie case that the term covered conduct in the assurance of discontinuance must be interpreted as including the promotion and marketing of Opana ER and other prescription opioids performed by third parties.

Instead, the language shows that the Attorney General's inquiry was directed at the Defendants' own statements, misstatements and omissions about Opana ER, particularly those made in printed materials posted on their public website and conveyed to their sales representatives to health providers, and that it concluded their marketing

practice, statements and omissions regarding that prior violated General Business Law 349 and 350.

Then again at motion sequence 236, again, the AOD issue came up. In connection with a petition seeking severance, the Court noted any potential prejudice to Endo flowing from the AOD is better dealt with a careful -- with careful instructions to the jury rather than trying the case three times, which was suggested in the petition, so three trials involving Endo.

There was a presumption that jurors will obey a judge's limiting instructions, see Robert A. Baker and Vincent Alexander evidence in New York State and federal courts Section 1-19, second edition.

Then you go through the rulings of this Court in connection with the form motions in limine, go to page 7, one-third down the page: Defendant Endo's motion in limine regarding its assurance of discontinuance with the State, the ruling, the Court will abide by its short form orders as concerns

the AOD.

That's a history of the litigation involving the AOD. It seems to the Court that, and I believe it's been stipulated, that as the AOD or anything in it reflects on the marketing of Opana prior to the -- up to the date of the AOD is out of bounds, but any other products are, in fact, not barred by the language of the assurance of discontinuance.

MR. REISMAN: Your Honor, if I may?

THE COURT: Is it Reisman or Reisman (pronouncing)?

MR. REISMAN: If I may just interject for a moment.

THE COURT: I beg your pardon?

MR. REISMAN: If I may just interject for a moment. Michael Reisman from the Attorney General's office for the State of New York.

In fact, there is no -- your Honor referred just now to a Stipulation. I am not aware of any such Stipulation. There is a -- the AOD is a document, of course, that the

Court has considered, but with respect to the issues at hand, the State late last night, apologies for the lateness, about 11:30, filed the letter with the Court attempting to delineate these issues, and the issue is that the AOD, as your Honor has observed, and as Endo's counsel has observed, relates to marketing of Opana ER. That evidence, as your Honor knows, may come in still if it addresses other issues, such as Endo's use of front groups and KOLs, third passage --

THE COURT: The third part involving as per this Court's prior short form orders is allowable.

MR. REISMAN: Okay.

THE COURT: If that's what you're saying. It specifically says that in the Court's prior determinations.

MR. REISMAN: Yes, your Honor.

In our letter last night we explained that because this is a public nuisance action, evidence concerning Endo's knowledge of abuse and diversion, including its knowledge gained through marketing and

research and so on regarding Opana ER, is within bounds. It is within bounds because, as your Honor saw in the letter, after March 1st of 2016, the FDA asked Endo, in a very extraordinary situation, to withdraw, reformulate Opana ER from the market due to the risks of abuse. And then ultimately Endo did that, and Opana ER, the reformulated version, was pulled from the market and, ultimately, the FDA withdrew its approval.

So our position is that the events post March 1st 2016 call into question: What did Endo know and when did they know it about the abuse and diversion of Opana ER?

And just one final point I would make, your Honor, and apologies if I was not clear about this on Friday, the AOD specifically concerns Opana ER. It does not concern Opana immediate release or Opana IR.

The Oxymorphone document that your Honor considered on Friday refers generally to Oxymorphone. It does not refer specifically to Opana ER or Opana IR. So that is another key distinction as we made in the letter that

was filed last night.

MR. SOLOW: Andrew Solow for the Endo Defendants.

THE COURT: Good morning, Mr. Solow.

MR. SOLOW: Your Honor, we don't disagree with your Honor's recitation of the history of the AOD motions, and I acknowledge there have been several of them.

If I could, your Honor, to simplify things moving forward. Your Honor's rulings were as stated. If we could just have a continuing objection on our position, as your Honor knows, we have now up in front of the Appellate Division on issues that your Honor has ruled are outside the AOD, that could certainly streamline things. That's my first request, your Honor.

THE COURT: The answer is yes, continuing objection -- continuing exception noted.

MR. SOLOW: Thank you, your Honor.

So turning then, your Honor, to the issue at hand is what appears to be a disagreement about the scope of marketing

that is covered conduct.

As your Honor knows, you asked on Friday for us to provide you a history in a submission to Miss Liccardi. I sent that email last night, I believe before the Shark Week viewing.

Your Honor, I call your specific attention to the covered conduct paragraphs of the AOD, paragraphs 11 through 35.

So while your Honor's short form orders refer, respectfully, in the shorthand to marketing, if you review those paragraphs of the covered conduct, there are quite a bit of subsections within there. And I'll just read those titles for the record, your Honor. There is covered within "Covered Conduct," the crush-resistance of reformulated Opana ER. The addictiveness of Opana. Certain statements distinguishing Opana ER from OxyContin. Certain statements that suggest you can achieve higher functions from Opana ER. Statements and omissions related to Opana ER studies. Detail of problem New York healthcare providers by certain Endo sales

representatives in connection with the promotion of Opana ER. Marketing statements directed to healthcare providers and patients.

So, your Honor, our position, within the scope of your Honor's short form orders, is that there is quite an extensive amount of "covered conduct" covered by the AOD. And all we are asking for, your Honor, consistent with what your Honor ruled on Friday, is those items are out of bounds for the Attorney General.

I did read Mr. Reisman's letter last night after at 10 to 12 and, your Honor, that's the issue. It appears to us there is an attempt at overreaching. Again, it harkens back to this concept of Courtwright -- Dr. Courtwright. That even though they seem to on one side be saying, yes, we acknowledge the marketing prior to March 2016 is out, they then say, but we're allowed to actually put that evidence in to support other claims about conduct that happened after 2017.

Your Honor, our position is that is a clear violation and out of bounds.

THE COURT: How about I'm willing to read to the jury that portion of the AOD?

MR. SOLOW: Well, your Honor, if I may. That's why I referred your Honor to the motion in limine, not to reargue the motion, but your Honor asked us to refresh your recollection.

THE COURT: You did.

MR. SOLOW: Right. And that's the issue, your Honor. It is a Settlement Agreement. As set forth in the case law in our motion in limine, the jury is not entitled to rely upon that.

I understand your Honor is now taking the position that the way to work around this are limiting instructions, that's the problem. You now have -- if you want to submit to the jury the issue of what covered conduct is, right, your Honor noted in the short form orders we neither admit nor deny any of that.

So on one hand we're now going to have

the jury deciding factual issues about why -- what the State is barred from proceeding under this cause of action. On the other hand I've got the same jury who's deciding the case against the Counties who are not allowed to know about the Settlement Agreement, because it's a Settlement Agreement, there is significant case law on that. There are not admissions, contrary to arguments your Honor has heard, it can't go to notice. So that's the problem, your Honor.

And I understand and respect the fact that your Honor has ruled on that, and we've taken it up on appeal, but that's the very issue, your Honor.

At a certain point, now that you have granted us a continuing objection around what is -- what your Honor has held is not marketing, for example, third-party marketing, the issue, your Honor, of now debating and letting the State put in as an issue of fact whether, for example, the Opana ER pre-approval training manual, which there

is deposition testimony establishing without a doubt that it is the Opana ER training manual, your Honor instructed the jury Friday they're not allowed to consider that for the State, but now we're going to have the State use that document just so the jury can determine that, in fact, it is covered under the AOD.

In the meantime, the jury, as the Counties' jury, is now hearing the very Settlement Agreement they're not entitled to hear because there are no admissions. It does not go to notice. So, admittedly, your Honor, that's the conundrum we have.

So I don't believe submitting -- reading paragraphs 11 through 35, which we neither admit nor deny to the jury, just to allow Mr. Reisman to use a document which, candidly, we think, as a matter of law, your Honor can determine is clearly, under your short form orders, covered as a covered conduct. That's the issue, your Honor.

THE COURT: Thank you.

Mr. Reisman, very briefly.

MR. REISMAN: Yes, sir, understood.

So to cut to the chase here, so there is a type of evidence regarding Endo, Endo's statements made during marketing to healthcare providers regarding the alleged crush-resistant properties of reformulated Opana ER. The State has no intention of introducing that type of evidence in this trial.

THE COURT: That's what I was referring to. Yeah, keep going.

MR. REISMAN: Yes. Yes. And I think we're agreed on that.

However, there is evidence concerning Endo's knowledge of abuse and diversion at the company level, at the marketing executive level, their call plan strategies, the extent of their detailing in New York, the extent of their payments to healthcare providers in New York, generally, as reflected in things like open database, all those sorts of, types of evidence are relevant to the question of what Endo knew about abuse and diversion of opioids generally and regarding Opana ER

specifically because, as we know, it was withdrawn from the market because of abuse, and that happened after March 1st 2016 and that brings into play, it brings within bounds, all of the evidence regarding what Endo knew.

THE COURT: Okay. Bring the witness in, please.

Make your objections in realtime.

MR. SOLOW: Thank you, your Honor.

THE COURT: I'm reserving all your objections and your exceptions. Make them in realtime also. The witness, please.

Oh, by the way, somebody noticed there may be some Jewish holidays coming up real soon. There was actually an article in the Long Island paper yesterday about three that are coming up real soon. So we'll make some inquiries with the administration here as to the availability of the facilities on those days.

Good morning, Doctor.

THE WITNESS: Good morning.

THE CLERK: Good morning, Doctor. I

remind you you're still under oath. You may be seated.

THE COURT: Bring the jury in, please. Thank you.

THE CLERK: All jurors are present and properly seated, your Honor.

THE COURT: Please be seated everybody. Ms. Conroy.

MS. CONROY: Thank you, your Honor. Good morning. Good morning, your Honor. Good morning, Dr. Lembke.

THE WITNESS: Good morning.

MS. CONROY: Welcome back.

THE WITNESS: Thank you.

CONTINUED DIRECT EXAMINATION OF DR. LEMBKE BY MS. CONROY:

Q. Just to sort of recap for everyone, last week we talked about addiction, correct?

A Yes.

Q. And withdrawal, tolerance, dependence, we talked about those concepts?

A Yes, we did.

Q. Okay. And you also spoke about dose and duration of the medication, how long someone took an

opioid and how high the dose might have been.

A Yes.

Q. And you explained chronic pain versus acute pain versus cancer pain.

A Yes.

Q. Okay. And you also talked about the methods that promotional messages could reach doctors. Could you just give me -- just remind the jury specifically what those were.

A Promotional messages reach doctors through what's called drug reps who are employed by the pharmaceutical industry to go out to doctors' offices and hospitals to market their products.

MR. PYSER: Objection, your Honor.

Just a clarification of the term "the pharmaceutical industry."

THE COURT: Yes. Ms. Conroy, we discussed that the term --

MS. CONROY: Yes.

Q. Do you recall that?

THE COURT: Dr. Lembke --

A Yes. So they're hired by certain opioid manufacturers to go out to the doctors' offices and hospitals to market certain opioid products, but

promotional messages are also conveyed through things like continuing medical education, which doctors are required to attend in order to maintain licensure.

The point of continuing medical education is to keep them up-to-date on science. Promotional messages are also conveyed through key opinion leaders who are leaders in their field, often from prestigious institutions who are in many cases receiving payment from certain opioid manufacturers to go and give these talks and promote what certain opioid manufacturers call their key promotional messages.

Opioids are also promoted through journal articles that are published in peer-review literature. These studies are sometimes funded by the opioid manufacturers and/or the authors are employed by certain opioid manufacturers or are paid consultants of certain manufacturers.

Certain opioid manufacturers also promote their messages by ingratiating themselves and lobbying certain regulatory bodies, so the State regulatory bodies or things like Joint Commission, which I talked about, which is an organization that

accredits hospitals without which those hospitals would not be able to receive payments from insurers like Medicare.

Certain opioid manufacturers have also created relationships with the Federation of State Medical Boards, and you'll remember the Federation of State Medical Boards is the organization that polices doctors to make sure that they are not engaged in unsafe and dangerous practices; that they are, as the hippocratic oath would say, first do no harm in their treatment of patients.

Q. Thank you.

The next topic I would like to get into with you is: What is the rate of addiction to prescription opioids when they are used to treat chronic pain patients? Do you know that rate?

A Yeah. So I've looked extensively at the scientific literature on this topic, which is to say the topic of how many people who are prescribed opioids by their doctor for a chronic pain condition have an opioid addiction, and the most reliable evidence shows that about 8 to 12 percent of patients getting an opioid from a doctor for a chronic pain addiction have an opioid addiction.

Q. That's 8 to 12 percent?

A Yes.

Q. What do you rely on for this figure?

A I rely primarily on a meta-analysis by Vowles. Meta-analysis is the study that combines a bunch of different studies into one and analyzes that data to come up with a number that represents all of those studies, and the Vowles is the definitive work on this question because it includes studies that specifically set out to find out the rates of misuse and addiction among chronic pain patients getting opioids from their doctor.

In comparison to other studies that have claimed to explore this question, which don't actually ask patients about misuse and addiction, but expect patients to volunteer that information and base their results on whether or not the patient brought it up themselves, and that's highly problematic, because misuse, opioid misuse, and opioid addiction are highly shameful behaviors. Patients would not naturally volunteer to their doctor that they're misusing the opioids their doctor is giving them.

So it's really essential when trying to

figure out the rates of addiction in this population that we do things like ask the patient about it or give them questionnaires that might explore that or test their urine for the presence of that drug or another drug. And Vowles has exactly done that, the study that I rely on.

It's taken new world patients from primary care clinics, from pain clinics, and it's included only those studies that actually sought to illicit the specific information about whether those patients were misusing or addicted to opioids.

Q. And so that study determined 8 to 12 percent of the patients would become addicted, correct?

A That study shows that among chronic pain patients taking an opioid, about 8 to 12 percent of them are addicted to opioids.

Q. And what does that mean with respect to the risk of addiction, how does that fall in line, 8 to 12 percent; what does that mean?

A So in medicine if you're trying to communicate to patients or providers whether or not a risk is common, uncommon, very common, a very good point of reliance is a scale from World Health

Organization. And the World Health Organization has said that if the risk of an adverse event from taking a drug is somewhere between 1 percent and 10 percent, then that's a common risk and they use the language of common. If the risk is greater than 10 percent, that is considered very common.

So according to the Vowles meta-analysis, with the risk of 8 to 12 percent, that means that the likelihood of being addicted in a population of chronic pain patients getting opioids is common to very common.

I would also add that this definition of common to very common is the same definition that can be found in some opioid manufacturer labels.

So, for example, a label for Opana ER, which is an Endo product, says in the label that a risk factor is common if it is between 1 and 10 percent of the population manifesting that problem as a result of taking the drug.

Q. And so the risk of addiction to prescription opioids when taken by a chronic pain patient is a far cry from rare, correct?

A That is correct.

Q. Now, I would like to move on to talk

with you about some specific promotional messages, and I'd like you to refer to what was marked as Exhibit P-27812. It is pretty big and it has -- it has an email on the front, but what I'm going to be asking you about is the document that has Kadian on it with a ribbon. 27812.

A Yes, I have that.

Q. Doctor, what is the drug Kadian?

A Kadian is a long-acting form of morphine.

Q. And if you could turn to, I think it might be easiest if I give you the actual page of the document and then I'll give you the Bates No. So page 28 of the document and the Bates No. is -- I'll put it up here -- Allergan MDL 01610549; do you have that page?

A Yes, I do.

Q. And we spoke a little bit about this on Friday. Do you see the term it says: Despite the improvements in pain management that have occurred over the past decade several barriers to effective pain control remain, and do you see the third bullet point, opioid phobia?

A Yes, I see that.

Q. Okay. And what is opioid phobia?

A Opioid phobia, in the way that it is used here, refers to an irrational fear on the part of the prescriber that their, that their patient will get addicted to opioids through their prescription.

Q. And now I'd like you to turn to page 31 of the document, and it's Allergan MDL 01610552. And if you could take a look at the very bottom it says: Although some progress has been made in providing good pain control to every patient, many factors still interfere with pain management. These include inadequate education of healthcare providers, fear of regulatory action by clinicians and inappropriate fear of addiction.

Do you see that?

A Yes, I do.

Q. Is it inappropriate for a clinician or a physician prescribing an opioid to a chronic pain patient to fear addiction?

A No, it is not.

Q. And why is that?

A Because, as I just said, the risk of becoming addicted through a doctor's prescription

for treatment of chronic pain is actually common or very common. Anybody can get addicted.

Q. And is it actually inappropriate in a learning manual for sales representatives, who are going to promote Kadian, to suggest that a fear of addiction is inappropriate?

A Yes. I believe that these kinds of statements are false and misleading and shouldn't have been included in training manuals.

Q. Next, I'd like you to turn to page 76 of the manual, and it is Allergan MDL 01610597, on page 76 of the manual. And do you see what I have highlighted here: Substance abuse will be seen in a few patients in every -- what does CBP stand for?

A Chronic benign pain.

Q. And what is chronic benign pain?

A Non-cancer pain.

Q. And it goes on to say: Perhaps largely because patients attempting to obtain opioids will eventually end up at a pain management practice. However, despite the continued unscientific beliefs of some clinicians, there is no evidence that simply taking opioids for a period of time will cause substance abuse or addiction.

Do you see that?

A Yes, I do.

Q. Is that true?

A No, it is not.

Q. Is it false?

A Yes, it's false.

Q. Now, if you go further down on the page, it says at the very last line: Educating clinicians about these guidelines will help to ease their fears of prescribing for patients with chronic benign pain, and it's under a section entitled: Guidelines for Opioid Use in Chronic Benign Pain.

Do you see that?

A Yes, I do.

Q. Can you explain to the jury what is meant by "guidelines."

A Guidelines, when that word is used, it has a strong influence on physicians, especially if it comes from an esteemed organization or was authored by leaders in the field.

Busy clinicians do not have time, the way that I have had time, to read them in articles to establish what the science really shows. They definitively rely on these condensed guidelines to

summarize the evidence for them so that they know how best to practice and care for their patients.

So guidelines tend to be very influential. That word alone carries weight in terms of informing a clinician's decisionmaking capacity.

Q. And let me just take a moment to ask you, given your expertise, you are an addiction specialist, correct?

A That's correct.

Q. Are you in a different position than other clinicians to evaluate national guidelines?

A Well, I think that I'm -- vis-à-vis the opioid epidemic?

Q. Yes, sorry. I'll be specific, yes, talking -- not with everything. Your specialty is addiction, correct?

A Yes.

Q. So are you in a different position than a clinician who has a different specialty in evaluating guidelines with respect to opioids?

A Yes. My background and knowledge allows me to really appreciate what is true and what is false about these guidelines on the treatment of

pain using opioids.

The average physician out there has very little training in addiction medicine. We get almost no training in medical school and, in general, very little in our residency, which is that apprenticeship period that follows medical school.

So the reason that I was able to see problems with opioid prescribing in my clinical practice much earlier than the average clinician is not because I am smarter or anything like that, it's because I'm an addiction medicine doctor so they were coming into my clinic, whereas other types of clinicians oftentimes they don't have -- well, they don't have the training and education, even under the best of circumstances, even with training, it's hard to detect, and then, of course, in modern medicine today very often there is not the opportunity of continuity of care to be able to see what happens to your patient after you prescribe the opioid.

So it's very, very hard for the average clinician to see that the opioid epidemic was happening as it was sort of exploding in our society.

Q. And if we could now take a look at page 77 of the manual, which is Allergan MDL 01610598, it talks about three national guidelines that have been published. Do you see that?

A Yes.

Q. And one is the American Academy of Pain Medicine; do you know what that is?

A Yes, I do.

Q. Okay. And what is that?

A That's what's called a professional medical society, and in this case it's a society of pain doctors and pain healthcare providers, people who specialize in the field of pain treatment.

Q. And is that the same for the American Pain Society, the same sort of group?

A Yes.

Q. And they published a consensus statement, The Use of Opioids for the Treatment of Chronic Pain; do you see that?

A Yes.

Q. And have you reviewed that document?

A Yes.

Q. And do you have an opinion as to whether or not it fairly states the risks of addiction to a

clinician prescribing opioids for a pain patient?

A That document states that it actually recommends opioids in treatment of chronic pain. So, again, we're not talking about short-term use for acute pain from which there is good evidence, we're talking about long-term use greater than three months of chronic pain for which there is no reliable evidence, and this document actually recommends the use of opioids in the treatment of chronic pain, despite the absence of evidence to support that.

Q. And if you take a look a little further down, another guideline is the Federation of State Medical Boards. It's developed model guidelines for the use of controlled substances for the treatment of pain. Can you explain for the jury what the Federation of State Medical Boards is?

A So, again, the Federation of State Medical Boards is like the police of doctors making sure that doctors are practicing safe medicine and if they're not, then the Federation of State Medical Boards can sanction that individual and potentially even revoke their medical license.

Q. And, Doctor, do you know or have you

researched how the model guidelines came about?

A Yes. So in my research, you know, one of the distressing and shocking discoveries for me was how many of these regulatory bodies, which I had just simply assumed were operating based on the best science, were, in fact, being lobbied by and funded by certain opioid manufacturers, including Defendants in this case.

And when I struggled to figure out why a guideline would recommend opioids in the treatment of chronic pain in the absence of evidence or profligate the misleading promotional messages that we've been talking about today and last week, what came to light in my research was that it's, it's the funding and a close relationship they had with certain opioid manufacturers that influenced their guidelines in absence of the evidence to support their recommendations.

Specifically I -- for example, there's an organization out of Wisconsin called the Pain and Policy Study Group, and the Pain and Policy Study Group was influential in terms of the Federation of State Medical Boards' guidelines. The Pain and Policy Study Group received tens of thousands of

dollars from certain opioid manufacturers and then aggressively lobbied the Federation of State Medical Boards to make it easier for doctors to prescribe opioids at very high doses without getting into trouble.

The Pain and Policy Study Group also lobbied state legislatures to pass Intractable Pain Act that basically made it possible for doctors not to prescribe opioids to patients who asked for them.

So, in other words, lobbying by opioid manufacturers, certain opioid manufacturers and payments from certain opioid manufacturers to the Federation of State Medical Boards through front groups like the Pain and Policy Study Group created a scenario in which doctors had no choice but to prescribe more opioids and, essentially, were duped by these misinformed guidelines and misleading messages.

If I could refer to my report, I'd like to share a couple of quotes from the leaders of the Pain and Policy Study Group. Would that be all right?

THE COURT: Doctor, there's an objection. Wait for Ms. Conroy to get there.

Thank you.

Q. Yes, if you could refer to your report, and I believe you do have some quotes from Pain and Policy Study Group leaders that you have identified, and if you could read those to the jury.

A So, first of all, just, you know, a financial list of contributions between 2000 and 2007 from the Pain and Policy Study Group out of Wisconsin attested to receiving tens of thousands of dollars from certain opioid manufacturers, including Endo Pharmaceuticals, Cephalon and Alpharma, and emails --

MR. BARTLE: Objection. Instruct the jury --

THE COURT: Is that mic turned on?

MR. BARTLE: Sorry. Harvey Bartle, Morgan, Lewis & Bockius. We ask you to instruct the jury again with regard to connection as to pain medicine.

THE COURT: Neither me nor my law secretary can make out what you're saying.

MR. BARTLE: Sorry, your Honor. We discussed this previously. We ask you to instruct the jury again with regard to

connection as to pain medicine.

THE COURT: I got it.

MR. SHKOLNIK: Your Honor, the witness is identifying the actual entities that made the payments.

THE COURT: I heard that.

I think the objection is really not an objection, it's a heads-up or a precautionary suggestion. And I told you this before, and I'll say it one more time, I'll probably say it a lot more as we progress. Eventually, the -- any witness' testimony has to be connected to a specific Defendant in the case because that's how you'll eventually determine whether there is or is not responsibility.

The suggestion was -- so the objection, I remind you of that and every time it happens, you'll know that. I do note that the witness' answer did name specific Defendants. So proceed.

MR. KNAPP: Your Honor, Tim Knapp on behalf of Allergan. Just an objection. There was a reference to Defendants. Of

course, Dr. Lembke mentioned Alpharma, which is not a defendant.

THE COURT: They've been told countless times "Defendants" is nondescriptive of any specific party in this lawsuit. That means, again -- I told you I'd say it again, I just did -- Defendants is just a generic term that does not identify a specific party. When the witness does identify a specific party, you may consider it, but, like I told you early on, I'll give you an instruction, certainly at the end of this case, as to your consideration of any, any expert testimony. You know, we anticipate quite a few. Proceed.

A I'm going to read to you a quote from a Dr. Georgeson, who was the Director of the Wisconsin Pain and Policy Study Group, in an email to a certain opioid manufacturer and he said --

MR. KNAPP: Your Honor, objection.

MR. HERSCHLEIN: Objection, your Honor.

THE COURT: What is the objection?

MR. HERSCHLEIN: The witness is reading from a document. She said she's reading a

quote. I guess it's an out-of-court statement that the witness is going to offer for the truth. We don't even know what document --

THE COURT: Hearsay objection?

MR. HERSCHLEIN: Hearsay. Apologies, your Honor.

THE COURT: Both of you say it's a hearsay objection.

MR. HERSCHLEIN: Apologies, your Honor.

THE COURT: Was this document that you're reading from, was it included in your report of things that you considered in connection with your testimony, Doctor; yes or no?

THE WITNESS: Yes, your Honor.

THE COURT: Overruled.

MR. KNAPP: Your Honor, I restate the objection that --

THE COURT: So noted.

MR. KNAPP: Thank you.

THE COURT: Thank you.

A And this is a quote. "We have improved state medical board policies. Many states now have

improved pain opioid policies that address concerns about regulatory scrutiny. We developed much of it from behind the scenes. We wrote the two models that states have used. The medical board guidelines from California and the model guideline of the Federation of State Medical Boards.

Similarly, another quote written from another Director, Dr. Gillson of the Pain and Policy Study Group, this time to a representative in North Dakota. He writes quote: Well, the representative from North Dakota where they passed one of these Intractable Pain Act that made it very difficult for doctors not to prescribe opioids if the patient requested them. The representative from North Dakota writes, quote --

MR. HERSCHLEIN: Objection, your Honor. Jurisdiction, North Dakota.

THE COURT: Folks, although it's a lovely state, why don't we skip that one.

Go ahead.

MS. CONROY: I think that's the only quote, your Honor.

MR. SHKOLNIK: Your Honor, I don't want to say anymore than the quote that's being

referenced shows the national policy applicable to the Federation of State Boards.

THE COURT: Ms. Conroy, rephrase the question.

MS. CONROY: Yes.

Q. Can you -- can you read the quote without referring to the actual state and also let me ask you first: Does the quote you're about to read refer to more than just an individual state guideline?

MR. HERSCHLEIN: Same objection, your Honor.

THE COURT: Overruled.

A Yes. It refers to the Pain and Policy Study Groups' actions nationally.

Q. Okay. Please proceed.

A So the quote to the executive or the email to the executive of the Pain and Policy Study Group said: "Did you guys have a hand in this one?" And the response was from Gillson of the Pain and Policy Study Group: "I'm impressed that you could detect our fingerprints. I will wear gloves next time. Yes, we work with Bruce Levi, Executive Director of the North Dakota Medical Association to

change the Intractable Treatment Pain Act to a general pain statute which also removed the prescribing restrictions for addicts."

Q. And, Doctor, these guidelines were intended to assist clinicians in feeling more reassured about prescribing opioids to pain patients, correct?

A I think it even went beyond that where it actually put pressure on prescribers to prescribe opioids, and it, essentially, changed the way that opioids are used in medicine.

Q. Doctor, I'd now like you to refer to page 84 of the document and it is -- I think we stopped the Elmo from jumping around -- Allergan MDL 01601605, and toward the top it says: At the end of the 1990s, however, the increasing frequency of diversion and abuse of opioid medications drew widespread public attention.

And that's true; isn't it?

A The end of the 1990s was really the beginning of the opioid epidemic.

Q. And then the last sentence of that paragraph: As a result, many clinicians became afraid to prescribe opioids for chronic benign pain;

do you see that?

A Yes, I see that, but I don't think that mischaracterizes --

THE COURT: The answer is just yes or no. You see that, correct?

Next question.

THE WITNESS: Yes, your Honor.

Q. And do you have an opinion about that?

A Yes, I do.

Q. And what is that?

A I think that this paragraph, although acknowledging the problem of diversion of opioid medication, gets it wrong in terms of the timing of when it drew widespread public attention or when many clinicians became afraid to prescribe opioids.

It really wasn't until about 2016 that the average clinician appreciated their role in the opioid epidemic, and where we started to see a shift and an awareness in the medical profession was late 1990s was really when the promotion took off which changed prescribing, increased prescribing, which led to the opioid epidemic.

Q. And if you look at the next paragraph it says most clinicians have only a superficial

understanding of what substance abuse really is, are not skilled at recognizing the symptoms of the problem and have no knowledge of the diversion and illicit resale of controlled medications. That's really what you were just talking about, correct, that it took a long time for clinicians to reach that understanding?

A Yes.

Q. And -- but in this document, at least to the sales force for Kadian, they are telling the sales force that clinicians don't have a good understanding, correct?

A Here in this document, yes, it states something that is true, that clinicians do not have a good understanding how to screen or intervene for addiction.

Q. And despite that, throughout the document we see references to low addiction rates, the benefits of opioids for chronic pain --

MR. KNAPP: Objection, Judge.

THE COURT: Sustained.

In fact, It's what's called repetitive direct, so go elsewhere. Thank you.

MS. CONROY: Great.

You can put that document away, Doctor.

I'm going to talk about Teva now, and I'd like to offer into evidence P18151.

MR. BARTLE: I would just like to see it, your Honor. I would like to see it.

MS. CONROY: No, we're getting it.

MR. BARTLE: Your Honor, we object. This is not disclosed.

THE COURT: Let me take a look and I'll ask a question or two.

MR. BARTLE: This didn't become an exhibit, your Honor, until last night.

THE COURT: The nature of your objection is?

MR. BARTLE: It's not in their disclosure. She never testified about it. It's not in the report. We obtained that exhibit last evening.

THE COURT: Mr. Bartle suggested that is not in the expert disclosure; is it?

MS. CONROY: It is not, your Honor. What I would like to do, this is -- I would like the doctor to assume these products and, subject to connection, offer this as an

exhibit.

THE COURT: Okay. You may pose a hypothetical question. All of you may pose hypothetical questions to any expert, but I will tell the jury the following:

An expert in a question and answer may be asked to assume certain facts as if they were in evidence. It's called hypothetical question. They want you to assume A, B, C, D, E and F or whatever, right.

The witness is permitted to answer. However, if those facts that are the basis of the hypothetical question are not independently proved during the course of the trial, that testimony will be not considered by you and I'll strike it.

MR. BARTLE: We maintain our objection.

THE COURT: So noted.

Q. Doctor --

THE COURT: No. Forget it, go ahead. It's fine.

Q. Doctor, I would like you to assume that Teva sold controlled substances, CT2 products that included Actiq; have you heard of Actiq?

A Yes.

Q. And could you describe what Actiq is?

A It's a -- essentially, it's a fentanyl lollipop.

Q. And what does that mean, like an actual lollipop?

A It means it's fentanyl on the end of a stick that you put in your mouth and the fentanyl is absorbed through the mucosa. So that's the way it gets into the bloodstream.

Q. And how would you describe fentanyl versus other opioid products with respect to potency?

A Fentanyl is one of the most potent opioid pharmaceuticals we have. It's 50 to 100 times more potent than morphine.

Q. Doctor, I would also like you to assume that Teva sold a fentanyl patch.

Have you heard of a fentanyl patch?

A Yes.

Q. And how does that work?

A It's the same molecule fentanyl with the same potency, but instead of getting it to the bloodstream through the mucosa in your mouth, it's a

patch that goes on the skin and it penetrates the skin and gets into the bloodstream that way.

Q. And I would like you to assume that Teva sold Fentora, are you familiar with Fentora?

A Yes.

Q. And what is that?

A That is a buccal tablet that, again, is not swallowed but rather held in the cheek and absorbed through what they call effervescence through the mucosa.

Q. And why is it that there are products for pain that are put into the mouth or can be transmitted just by putting up into your cheek?

A There are instances when patients can't take the medication in other ways. For example, they might not be able to swallow; perhaps they're at very end of life or they've had some severe type of chemotherapy and they maybe got erosive ulcers in their throat; perhaps they're intubated in the ICU, which means they got a breathing tube down their throat.

So it's important to have multiple modalities for getting the medication, in this case opioids, into the system.

Q. I would also like you to assume that Teva sold generic Actiq, as well as generic OxyContin.

Are you familiar with OxyContin?

A Yes.

Q. And who originally manufactured OxyContin?

A OxyContin was originally manufactured by Purdue Pharmaceuticals.

Q. And what is either generic OxyContin or OxyContin; what is it actually?

A OxyContin is a long-acting form of oxycodone and it's dosed approximately twice per day. It's a very -- it's also a very potent opioid.

And do you want me to get into the unique aspects of the capsule?

Q. No, it's okay, just what it is, and it's not fentanyl, correct?

A It's not fentanyl, but they are both in the class of opioid.

Q. Thank you.

MS. CONROY: I would like to offer into evidence P18376.

THE COURT: While they're marking that,

during that question and answer, Dr. Lembke was asked to assume five or six facts, all right. Those facts must be independently established in order for that evidence to be admissible, but, like I said, we allow experts to answer hypothetical questions. Understood?

MR. BARTLE: Your Honor, I don't have an objection presently subject to laying a foundation. The witness has no personal knowledge of this document. To the extent it does come in later, just note our objection.

THE COURT: Thank you. Let me see the document.

You've heard the objection?

MS. CONROY: I'm sorry, your Honor?

THE COURT: I said you heard the objection?

MS. CONROY: Foundation?

THE COURT: Also, the witness has no personal knowledge of the document and foundation was a secondary objection.

Do I have that right, Mr. Bartle?

MR. BARTLE: It's both, your Honor.

What I'm saying is we understand it's a document she relied upon in her disclosure. She can give her opinions about this document. But she did not create it, she did not make it, she is not employed by the company. So whether or not it comes in later --

THE COURT: You stipulate to CPLR 4540(a) document; yes or no?

MR. BARTLE: It was produced.

THE COURT: Say again.

MR. BARTLE: Just note my objection. I'm not trying to prohibit the witness from talking about it.

MS. CONROY: Yes, it was produced, your Honor.

MR. PRESNAL: And offered by his client.

THE COURT: Okay. Overruled.

Exception duly noted.

Q. Doctor, is Exhibit P18376 a type of document that you would rely on in formulating your opinions in this case?

A Yes, it is.

Q. And did you consider Exhibit P18376 in

formulating your opinions?

A Yes, I did.

Q. And what is the document?

A This is a 2005 Actiq marketing plan, so internal documents describing the company's plan for marketing their drug Actiq, the fentanyl lollipop.

Q. And let me show you the front page of the document, and is that the lollipop?

A Yes.

Q. Now, I would like you to turn to page 39 of the document, then I will get to the Bates No. -- Bates Teva MDL A 100 -- I'm sorry -- 01159362.

I direct your attention to where it says abuse, addiction and diversion; do you see that?

A Yes, I do.

Q. And it says: Unfortunately, undertreatment of pain continues to be a widespread problem; is that true?

A Pain is a huge problem in this country, but to say that it is undertreated and to then follow that with a discussion of prescription opioids is one of the ways that certain opioid manufacturers shamed doctors into prescribing opioids.

By juxtaposing the problem of the undertreatment of pain with marketing or promotional messages about their product, they essentially were communicating to doctors, it's undertreated because you're not willing to prescribe opioids.

So, yes, pain is a problem; opioids are not the answer.

Q. And if you could just read to the jury the next sentence, because I think that actually explains what you just said.

A It has been postulated that one reason why pain is undertreated is due to physician fear of prescribing opioid analgesic medications, opioid phobia.

Q. And what does that mean?

A That essentially means that the problem of undertreatment is the physicians' fault, because they're not willing to use opioids to treat pain.

Q. And we saw just a few minutes ago with the Kadian document, we saw the term opioid phobia; do you recall that?

A Yes.

Q. And here we see it a little different, opiophobia here in the Teva document, the Actiq

document, correct?

A Yes. There are two common spellings. One is with a D at the end of opioid. One is without the D. They're the same term, essentially.

Q. And being used by two different Defendants?

A Yes. This was a common key message that appears in multiple promotional documents.

THE COURT: Okay. There's an objection.

MR. BARTLE: I'm sorry, your Honor, Ms. Conroy states two different Defendants.

MS. CONROY: The Kadian Defendant that we just looked at.

THE COURT: I'll sustain the objection.

The portion of the testimony that's not specifically distributed, i.e, to Defendants, is stricken. I'm not precluding you, but be more direct in your examination.

Q. This morning which two Defendants did we see a reference to either opioid phobia or opiophobia?

A Kadian, Allergan Pharmaceuticals, and I believe we saw records as well to Endo, or not yet.

Q. Not yet, but here, this one.

A This is Teva, Cephalon.

Q. Thank you.

Now, was Actiq indicated for specific kind of pain?

A Yes. So Actiq, the fentanyl lollipop, was FDA-approved for breakthrough cancer pain. Very specific and narrow indication, breakthrough cancer pain.

Q. And what does that mean if a drug is approved for a specific use by the FDA? And please use this as an example, the Actiq and cancer pain versus chronic pain.

A That means that if a physician were to prescribe Actiq, the fentanyl lollipop for something other than breakthrough cancer pain, they would be prescribing it off-label, off of the FDA label.

Q. Now, I'd like you to turn to page 45 of the document and it is Teva MDL 01159368, and I would like to direct your attention to Actiq, 2005 positioning. What does that mean?

A That means that this is about how they were going to position their promotion of the product to prescribers.

Q. And if you take a look at the section in

bold, can you read that for the jury.

A (READING:) Actiq is fentanyl in a unique oral transmucosal delivery system that provides the most rapid onset of analgesia of any non-invasive opioid formulation available which makes it the ideal agent for BTP or rapid onset, such as BTCP.

Q. And what does BTCP stand for?

A Breakthrough pain.

Q. And what is rapid onset pain?

A Pain that comes on all of a sudden.

Q. Does breakthrough pain only occur with cancer?

A No.

Q. What about rapid onset pain?

A That is also not exclusive to cancer.

Q. So what is being said here is that Actiq is an ideal agent for breakthrough pain or rapid onset pain, both of which are not exclusively cancer pain?

A That's correct.

Q. And if you could now turn to page 37 -- actually, we'll cut it a little bit short and go to page 25.

And page 25 is Teva MDL 10 -- I'm sorry -- 01159348, and at the top of the page, and I'll show you on page 24, the section we're looking at is physician usage. What does that mean?

A That means how doctors were using the Actiq fentanyl lollipop.

Q. And could you read this top two sentences or just read the first sentence on the top.

A (READING:) Based on physician reporting, 90 percent of Actiq use is for breakthrough pain outside of cancer, with the majority of use 55 percent of the total being for chronic back pain. This broad use of Actiq suggests there are many prescribers who...

Q. And you can go on.

A ...understand or are experienced prescribing fentanyl, treat the pain pathophysiology, not the disease state or the etiology. Etiology means cause of the pain. Understand the benefit that Actiq affords their patients and are comfortable utilizing it beyond its labeled indication.

Q. What's happening here, Doctor?

A Essentially what this is saying is that the corporation recognizes that out in real life Actiq, the fentanyl lollipop, is most commonly prescribed for people who don't have any kind of cancer at all, and that in current prescribers of the Actiq fentanyl lollipop, most of their patients have things like chronic low-back pain.

Q. And is there a risk of addiction dependence, overdose and death with the increased use of a fentanyl lollipop like Actiq?

A Absolutely. So one of the core features of the opioid epidemic is not just that opioids were being prescribed for more people at higher doses for longer periods of time, but that they have been prescribed for broader indications, meaning for minor pain conditions, for chronic pain conditions, the types of conditions for which there's no evidence that the benefits of opioids outweigh the risks.

Q. And, Doctor, let's for a minute talk about some of the practical ways that this sort of promotion would take place of Actiq.

If you could turn to page 78 of the document Teva MDL A 01159401, and what I'm showing

you is a part of the appendix which had the budget for 2005, the tactical budget, and do you see the section that says Medical Education?

A Yes, I do.

Q. Okay. And can you describe at least what is expected to be budgeted and for what purposes.

A This shows that the makers of Actiq were willing to pay millions of dollars to promote their product to physicians and other healthcare prescribers. You could see here that they spent more than 9 million dollars to support continuing medical education.

Remember, that's the mandatory educational meetings doctors have to go to to stay up to date and to keep their license. Consultants meetings, that's the meetings with their key opinion leaders and other individuals who will help them promote their product, and also speaker training, so that's where they would create slides and essentially create a script for key opinion leaders to go out to educational conferences and use that script in order to promote their product and promote opioids more generally.

Q. And when you were just referring to conferences, is that the increased presence at pain conferences?

A Yes. So a major strategy was to go to meetings and gatherings of professionals in the field of medicine.

So I talked a little bit about professional medical societies, like the American Academy of Pain Medicine, the American Pain Society where everybody in the field comes together once or twice a year to be at a conference, to be educated at that conference, and this shows that money was spent in order to be at those conferences, to be able to meet and greet with doctors, to tell them about their product, to give little promotional gizmos: hats, pens.

Q. And if we could take a look at page 80, Teva MDL A 01159403, this is appendix 8, which is the 2005 medical meeting plan, and I would direct your attention to where I've highlighted.

Can you explain to the jury what this is.

A This is just detailing a specific conference with the date and the location and how

many specialties in the field of pain might have shown up at that conference.

Q. So this is an American Pain Society conference that will take place in late March in 2005 in Boston, correct?

A Yes.

Q. And the products that will be discussed, GAB and Actiq, and then if you look above the specialty, what does that mean when it says specialty pain? What does that mean?

A Doctors who specialize in treating patients with pain.

Q. And so they would anticipate that 2000 doctors would be in Boston for this American Pain Society conference and their specialty would be pain, correct?

A That's right.

THE COURT: Members of the jury, I did tell you if any of you need a break just let the court officer know, okay. Don't be shy.

Q. I'm going to move on to another document. This one is in evidence, P24979, it's the Fentora Learning System, and I think you have it up there, Doctor, 24979, and it has an email on the

front of it, but it looks like --

THE COURT: Hold off. Two of our jurors would appreciate a break.

MS. CONROY: Okay.

THE COURT: We'll take a 20-minute recess. I think it takes 20 minutes just to get through the system, so to speak, so we'll take a 20-minute recess.

Don't discuss the case amongst yourselves or with anyone else until the appropriate time.

Thank you.

THE COURT OFFICER: All rise. Jury exiting.

(WHEREUPON, a short recess was taken.)

THE CLERK: Come to order. Supreme Court is back in session.

THE COURT: Be seated. Just so you know, I checked the holiday dates on the recess, we're okay. The next time the school is closed is Labor Day.

Okay, bring the jury back.

THE CLERK: I remind you, Doctor, you're still under oath.

THE COURT OFFICER: All rise. Jury entering.

THE CLERK: All jurors are present and properly seated.

THE COURT: Be seated. Thank you.

Ms. Conroy.

CONTINUED DIRECT EXAMINATION OF DR. LEMBKE BY MS. CONROY:

Q. Doctor, just before the break we were looking at P24979, it's the Fentora Learning System; do you have that?

A Yes.

Q. And could you remind the jury what is Fentora?

A Fentora is the fentanyl tablet that goes into the cheek that is absorbed transmucosally.

Q. And who manufactures and sells Fentora?

A Teva, Cephalon.

Q. And I'd like to direct -- and what is Fentora indicated for?

A Breakthrough cancer pain.

Q. If you could take a look at page 40 of the document and it is Teva MDL A 00890346, section that says: Like patients, caregivers may need

reassurance that few people using opioids for a legitimate medical reason become addicted to the drug. Do you see that?

A Yes, I do.

Q. "Few people," that's not common or very common, correct?

A To say "few people" is inconsistent with the science showing that addiction is common or very common in people being prescribed opioids for chronic pain.

Q. Is that statement false?

A Yes.

Q. And the statement goes on and says: And that physical dependence to a drug is easily overcome to scheduled dose decreases if the patient improves to the point where opioids are no longer needed; do you see that?

A Yes, I do.

Q. Is physical dependence to a drug easily overcome?

A Not for most people, no.

Q. And why is that?

A Because the brain and the body adapts to the presence of the drug, so literally it changes

the brain. So when a dose goes down or the medication is stopped abruptly, patients will experience the classic syndromes of opioid withdrawal. And even beyond the immediate two to three weeks of acute physical withdrawal, there can be a persistent psychological syndrome called protracted abstinence syndrome characterized by ongoing irritability, depression, anxiety, insomnia and craving for the drug.

Q. Is there a difference between physical dependence to fentanyl versus oxycodone or a different type of opioid?

A Well, because fentanyl is so much more potent than other opioids, you're effectively giving that person more opioids. We do know that the risk of addiction is dose and duration dependant, and addiction is commonly accompanied by physical dependence.

And when I say that it's dose and duration dependant, what I mean is that the more opioid you're on, and the longer you're on them, the more likely you are to become addicted to that opioid.

Q. Is it false that physical dependence to

a drug is easily overcome through scheduled dosing decreases?

A That's false for the vast majority of people, yes.

Q. If you could turn to page 45 of the document, which is Teva MDL A 00890351.

And I think we took a look at this document the other day. In patients without personal or family history of substance abuse addiction resulting from exposure to opioid therapy is uncommon. Is that statement true?

A No.

Q. Because the risk of addiction is common to very common, correct?

A Yes. And because -- although it is true that if you have a personal or a family history of addiction and your doctor gives you an opioid for pain, you're more likely than the average person to get addicted to that opioid because of the genetic or inherited factors that we talked about, as well as the childhood nurture factors.

But even though that is true, the biggest risk of getting addicted to an opioid that a doctor gives you for pain is how much they gave you

and how long you were on it, and that risk trumps the other inborn genetic risks based on personal or family history.

Furthermore, even with no personal or family history of getting addicted to anything, it's still common for patients to get addicted when they get put on an opioid by their doctor, and doctors can't predict who will and will not get addicted once they get started on opioids.

Q. Is this statement that addiction risk is uncommon false?

A Yes. So this is, again, a reference to that Porter and Jick letter to the editor, which was cited as a study and isn't really a study. Remember that hospitalized study, study of hospitalized patients showing that there are more than four out of 11,882 developed a "narcotic addiction" and how that is not really evidence because it was a hospitalized sample, which is not consistent with the real world population of outpatients walking around with things like chronic low-back pain, and because many of those individuals just got a single dose or got a very low dose for short duration.

So, again, this is misleading because it looks like it blends science in numbers by using a citation that wasn't robust enough to be used for this kind of statement.

Q. And now if you could turn to page 49, Teva MDL A 00890355. You're going to be looking at the top of the page. It says: Pain appears to reduce the euphoric effects of opioids so people taking opioids to manage their pain may be at a lower risk for addiction.

What are they saying here?

A So this is a really important misleading key message that was put out there by certain opioid manufacturers and it had a huge impact on doctors.

Q. Doctor, can I just stop you there.

We can talk specifically, this is a message being put out by Teva with respect to Fentora, correct?

MR. BARTLE: Objection, your Honor. I'm sorry, your Honor, never mind. Withdraw the objection.

Q. I'm sorry, you can go ahead, Doctor.

THE COURT: Go ahead.

A Okay. So just to answer the question,

what this statement essentially stands for is that there's something biologically unique about a patient who has pain, such that if they take an opioid that their doctor gave them for the pain, they're somehow magically immune from getting addicted.

This was very persuasive for doctors trained starting in the late 1990s for the last two decades.

In doing research for my books I talked to many doctors about what their education and impressions were of opioids for pain and many of them told me that they were convinced by statements like this that somehow as long as they were prescribing the opioid to a real patient with real pain, that the patient was very unlikely to get addicted. That's how we ended up with the opioid epidemic. This is patently not true.

Q. Is this statement false?

A Yes, it is.

Q. Let's take a look at the next paragraph where it says: Certain behaviors are sometimes mistaken for addiction. If patients receive inadequate pain relief they may exhibit drug seeking

behaviors. This is called pseudoaddiction.

What is pseudoaddiction?

A Pseudoaddiction is a made-up term and it essentially means fake addiction.

Q. And where does this originate from?

A This term was originally coined by two authors who published a case report in a peer-review medical journal. A case report is a description of a single patient.

And what they described was a young man, who I believe had leukemia, who had pain and it was being treated with opioid, but who engaged in what's called drug seeking behaviors, like making up, you know, gestures to demonstrate that he was in more pain, putting a lot of work into getting more pain medicine, which these authors then describe as pseudoaddiction, essentially, essentially saying that if you have a patient who is demonstrating all the signs and symptoms of having become addicted, they're not really addicted, they're pseudo addicted and in pain, and you need to go up on the pain medicine.

And the only real criteria for sorting out, according to these -- this concept, who's

addicted and who's pseudo addicted is to ask the patient if they have pain, and if they say yes, then you should go up on the pain medicine, because you should treat to whatever the patient says, ignoring anything else. That is essentially what happened.

And the problem with this concept was that it made it very difficult for prescribers to diagnose addiction in the context of treating a patient with opioid for pain, because even when you saw somebody who was doing all the things that people with addiction do: lying, you know, getting drugs from multiple prescribers, you know, doing a lot of thinking, a lot of effort to get more opioids, you really weren't allowed to say that they were addicted because you had to call them pseudo addicted to increase the opioid.

The other tragic impact of this concept is it really deprived those individuals who became addicted through their doctors' prescriptions getting appropriate addiction treatment that might have saved their lives.

Q. Doctor, is using the concept of pseudoaddiction false promotion?

A Yes. It's false, but it also encouraged

higher dosage of opioid prescribing, right, because the solution for pseudoaddiction was to go up on a meter.

MR. BARTLE: I'm going to object to this question and answer and request a short sidebar on this. It's outside the scope.

THE COURT: Give me the question back, please. Oh, by the way, you're all directed to the Court's decision short form order dated November 12th 2020 as concerns --

MR. BARTLE: I believe that's what I'm referring to, your Honor.

THE COURT: So you're suggesting he's outside the scope of an allowable area?

MR. BARTLE: Correct.

THE COURT: Okay. Read me the question, please.

(WHEREUPON, the requested portion was read by the reporter.)

THE COURT: Marketing is out of bounds; promotion is not.

Overruled.

Q. I believe you actually answered the question already; did you?

A Yes.

THE COURT: The Court notes in the footnote there's a distinction between the two that's subject to consideration.

Go ahead.

MS. CONROY: Thank you, your Honor.

Q. Doctor, is there any empirical evidence to support the concept of pseudoaddiction?

A No. In reviewing the literature there is no empirical evidence to support the concept of pseudoaddiction. No scientific evidence to support this concept.

Q. You can put that document away, doctor, or both of those documents.

And for my next question, doctor, I would like you to assume that there is an Endo document entitled: Opioid Analgesic Advanced Sales Training from 2003, okay?

MR. HERSCHLEIN: Objection, your Honor. That's improper.

THE COURT: Let's see where it goes.

Oh, by the way, this document you're asking the witness to assume, has it been exchanged?

MS. CONROY: Yes, your Honor.

THE COURT: Exchanged in the course of discovery?

MS. CONROY: Yes, it was. And it was used by both Defendants and Plaintiffs in opening statements.

THE COURT: Okay.

MR. HERSCHLEIN: Your Honor, it's not in her report. It's not part of her referenced materials.

Your Honor ruled clearly last week that it's out of bounds. Those are your words.

THE COURT: This is a very late disclosure?

MR. HERSCHLEIN: Last night, 7:12.

THE COURT: Okay. Sustained.

MS. CONROY: Thank you, your Honor.

THE COURT: I don't know if you have to thank me for sustaining your objections, but I'll take it.

MS. CONROY: That's okay. We'll get to that document.

Q. I would like to draw your attention to a document that is in evidence, P23771, and it's the

Oxymorphone learning system.

MR. HERSCHLEIN: Your Honor, at the appropriate time we would ask for the limiting instruction that you gave on this document last week, because we're coming back to it.

THE COURT: Okay. You have to give me a clue which limiting instruction I gave.

MR. HERSCHLEIN: It has to do with the AOD.

THE COURT: Oh, okay.

There was, members of the jury, there was a prior dispute between Endo and the State of New York which was resolved back in 2016. It was resolved by something called an AOD, an assurance of discontinuance. That thing that we call an AOD eliminated certain product and certain conduct from consideration, certainly going back in time.

As we progress I will, in all probability, be giving you additional instructions regarding that. The medication is Opana, it was the subject of the dispute, and that dispute was resolved. Resolved,

resolved with no admission of liability or fault, all right, so keep that in mind.

Was that the one I gave or close enough?

MR. HERSCHLEIN: Pretty close, your Honor. Also Opana ER.

THE COURT: Okay, Opana ER, yes.

MR. SHKOLNIK: Your Honor, the instruction is supposed to be limited to the State and not the Counties.

THE COURT: By the way, the Counties, yeah. The Counties were not a party -- thank you for reminding me -- the Counties were not a party to that dispute, so whatever you may hear during Miss Conroy's examination, to the extent that it refers to this Opana ER and has some connection to that thing I called an AOD, it's not applicable to the State.

Go ahead.

Q. Doctor, if you would turn to page 25 of the Oxymorphone Risk Management Program.

And do you see where it says, Approach to selling OxyContin?

A I do.

Q. And who was the manufacturer of

OxyContin?

A Purdue Pharmaceuticals.

Q. And which Defendant is writing this document?

A This document is being written by Endo Pharmaceuticals.

Q. And it says: With the initial success of OxyContin, Purdue put a lot of effort into marketing and promoting it. They promoted the use of OxyContin for both cancer and non-cancer pain, significantly increased their sales force and used multiple promotional approaches.

Do you see that?

A Yes, I do.

Q. And you're familiar with that from your research, correct?

A Correct.

Q. If we could turn the page.

Endo references possible factors contributing to problems. Do you see that?

A Yes, I do.

Q. And it says: Once the abuse and diversion problem with OxyContin became known, the reasons for contributing to the problem began to be

investigated; do you see that?

A Yes, I do.

Q. And then down a little bit further it talks about improper marketing; do you see that?

A Yes.

Q. You had read through this document?

A Yes, I have.

Q. Was Endo aware of the consequences of the misleading and false promotion by Purdue of its drug OxyContin?

MR. HERSCHLEIN: Objection, your Honor. I think there's a mill on corporate knowledge.

THE COURT: The way the question was put to you I'll sustain the objection.

You're asking what somebody was aware of, so even though it's an inanimate object, a corporation, you can't call for the operation of the mind of the entity.

Go ahead. I'm not precluding you, but I'm suggesting another way perhaps.

MS. CONROY: I'll rephrase, your Honor.

Q. Were you able to determine from the pages 26 and 27, information that Endo was able to

determine from the problems that Purdue faced with OxyContin?

THE COURT: Just say yes or no.

A Yes.

Q. And what were they?

A Well, it's clear from this document that Endo Pharmaceuticals was well aware that Purdue was cited by the FDA for things like advertisements in journals, for suggesting that OxyContin could be used as initial therapy or was often referred to as first line treatment. That it could be used in older people. And importantly, that Purdue overstated the benefits and minimized the addiction risk of its products.

MR. HERSCHLEIN: Your Honor, I would object and move to strike the answer which began "it was clear that Endo was well aware." It's directly contrary to the ruling.

THE COURT: I'll strike -- that portion of the answer is stricken. If you can go to a specific -- in other words, when I strike it, remove it from your mind, that portion of the answer. You can go to the document.

MS. CONROY: I will, your Honor.

THE COURT: Thank you.

Q. Doctor, do you see where it says, under Improper Marketing, there are explanations of what Purdue was cited for by the FDA; do you see that?

A Yes, I do see that.

Q. And one was for several advertisement violations between 2000 and 2003; do you see that?

A Yes.

Q. And this is an Endo document reciting this, correct?

A That is correct.

Q. And then they also talk about an advertisement in a medical journal that implies that OxyContin had been studied in all types of arthritis; do you see that?

A That's correct.

Q. Is arthritis a chronic pain -- something that creates chronic pain?

A Yes.

Q. It also talks about OxyContin could be used as initial therapy in elderly patients without support for any of those plans; do you see that?

A Yes, I do.

Q. And that is Endo reciting what it understood Purdue to have done that was improper?

A Yes.

Q. Then it says: A second more serious citation was for journal ads.

What are journal ads?

A They're advertisements in medical journals that doctors read.

Q. (READING:) And those ads minimized the drug's risks and overstated its efficacy; do you see that?

A Yes, I do.

Q. (READING:) Failed to present information from the boxed warning on potentially fatal risks and abuse potential and omitted information about limitations on its indication; do you see that?

A Yes, I do.

Q. When it talks about limitations on its indication, what does that refer to?

A That means they went beyond what the FDA said the drug could be used for.

Q. And is that similar to what we were talking about when we were talking about Fentora and

Actiq being indicated only for cancer, for breakthrough cancer pain?

A Yes, that's a similar example.

Q. Then it says: Purdue's website for OxyContin also had information inconsistent with its labeling and lacked risk of information for use in postoperative pain; do you see that?

A Yes, I do.

Q. And is it your opinion that this information written by Endo in its Oxymorphone document was known by Endo?

A Yes. If they wrote it in their document, they clearly knew it.

Q. Then it talks about several videos produced by Purdue were found to contain other substantiated claims about patient's quality of life, inability to perform activities of daily living while minimizing risks and claiming a low likelihood of addiction; do you see that?

A Yes, I do.

Q. It's your opinion Endo was aware of this and aware that Purdue had been found to have improperly marketed OxyContin by the FDA as a result of some of these claims?

MR. HERSCHLEIN: Objection, your Honor.

THE COURT: Can I hear that question again. Can you read that back, please.

(WHEREUPON, the requested portion was read by the reporter.)

THE COURT: Overruled.

You can answer.

A Yes, it's clear to me that Endo Pharmaceuticals was aware of what Purdue, what they wrote about it in their own document.

Q. If you could turn to page 14 of the document, the actual page 14. Could you read where I have highlighted. Can you see it?

A Yes, I can see it. Do you want me to read it out loud?

Q. Oh, read it out loud, I'm sorry.

A (READING:) Physicians can differentiate addiction from pseudoaddiction by speaking to the patient about his/her pain and increasing the patient's opioid dose to increase pain relief.

Pseudo-addictive behaviors, such as clock watching, counting down the time until the next dose will resolve when the pain is properly treated.

Q. Are those statements false?

A Those are false and misleading, yes.

Q. Doctor, in your opinion, did Endo jump on the Purdue bandwagon with respect to the promotion of its drug Oxymorphone?

MR. HERSCHLEIN: Object to the form, your Honor.

THE COURT: Sustained. Sustained.

Q. Is the pseudoaddiction claim false promotion, in your opinion?

A Yes, it is.

Q. Thank you. You can put that one away.

Doctor, have all of the prescription opioids that we've talked about today been approved by the Food and Drug Administration, the FDA?

A Yes, they have.

Q. And have you assigned some responsibility for the opioid epidemic to the FDA?

A Yes, I have.

Q. Are you an expert in FDA regulations?

A No, I'm not.

Q. Do you understand that Dr. Kessler, former Commissioner of the FDA, is going to testify here?

A Yes. That is my understanding.

Q. Are you familiar with the labels that come with prescription opioids?

A Yes.

Q. And do those labels include a risk of addiction and overdose?

A Yes, they do.

Q. Now, do doctors get more of their information about prescription opioids from labels or from somewhere else, in your opinion?

A From somewhere else. Labels are not the main source of information for doctors. It's all the other things we talked about: continuing medical education, key opinion leaders, journal articles, the Joint Commission of Quality Measures Guidlines, the Federation of State Medical Boards tells them what they need to do, what their teachers tell them they need to do.

Q. Does the FDA sell opioids?

A No, it does not.

Q. Do they profit -- does the FDA profit from opioid sales?

A Not as far as I know, no.

Q. Does the FDA make any promotional

statements about opioids?

A No.

Q. Do you draw any distinction between the responsibility of the manufacturing Defendants, Endo, Allergan and Teva on the one hand from the FDA on the other?

MR. BARTLE: Your Honor, I still make my objection based upon your prior ruling regarding scope of this witness' testimony.

THE COURT: Can I have the question back.

(WHEREUPON, the requested portion was read by the reporter.)

THE COURT: Overruled.

Just yes or no.

A Yes, I do draw a distinction.

Q. And what is that distinction?

A To me, the responsibility and obligation of certain opioid manufacturers promoting these products is much greater in regards to the opioid epidemic. Essentially, they were maximizing profits at the expense of public health and safety.

THE COURT: Ms. Conroy, the nature of your objection was, I think, was that you

mentioned three parties in connection with one question, and I think it was suggested --

MR. BARTLE: That was not the nature of my objection.

THE COURT: It would have been a good one.

MR. BARTLE: It wasn't the one I made.

THE COURT: It would have been a good one. I think Saturday Night Live would say, Never mind...

Go ahead.

Q. Dr. Lembke, I want you to assume that each of the three Defendant manufacturers, Endo, Teva and Allergan in their opening statements --

MR. BARTLE: Your Honor, I would object to this question with regard to corporate separateness.

MS. CONROY: All right, I'll do it that way, that's fine.

THE COURT: Sustained.

Q. I want you to assume that Endo in its opening statement by Mr. Herschlein argued that the New York State Department of Health itself repeated the message that addiction is rare in patients

taking opioids for pain.

Does it surprise you that the New York State Department of Health would make a statement like that: Addiction is rare?

MR. HERSCHLEIN: Objection, your Honor. I believe your Honor ruled last week this witness is not to be commenting on attorney statements.

THE COURT: No, no, I don't think I did. I certainly don't think I did. I customarily will allow a witness to be confronted with a suggestion that was made. However, I don't like the word "surprise."

MS. CONROY: Okay.

THE COURT: So sustained.

MR. HERSCHLEIN: Second objection, your Honor, is this is not in her report.

THE COURT: This is not what?

MR. HERSCHLEIN: This is not within the witness' expert report.

THE COURT: Okay. Overruled. You can answer.

Q. Let me rephrase --

THE COURT: Take the word surprise out.

Use a different word. There's got to be a better one.

Q. Was that unexpected?

A Yes.

Q. And why is that?

A The fact that these misleading messages appear in other places is evidence of the effectiveness of the promotional campaign.

Certainly opioid manufacturers were able to infiltrate every layer of medicine and medicine regulatory bodies and policymakers in order to promote opioids as a class, which in turn increased sales of their opioid products.

Q. And would your answer be the same if a statement was made by Teva or by Allergan?

A Yes, it would.

Q. Thank you.

Now, we have looked at several promotional statements that were made by certain opioid Defendants, correct, over the last three days?

A Yes, that's correct.

Q. And were those messages, some of them, and I'll go into them specifically, misleading?

A Yes.

Q. And one of them is addiction is rare; is that right?

A Well, the word "rare" itself is not, is not necessarily always used. Sometimes the word is uncommon or there's minimal risk as long as you're prescribing to a patient with pain.

Q. Did you see promotional statements talking about addiction is rare or uncommon or minimal risk or something along those lines when you looked at Allergan Finance, LLC documents?

A Yes.

Q. Did you see such misleading or false messages about addiction in Endo documents?

A I have seen such statements in Endo documents, yes.

Q. And what about in Teva documents?

A Yes.

Q. Pseudoaddiction, did you see misleading messages about pseudoaddiction in Allergan Finance documents?

A Yes.

Q. In Endo documents?

A Yes.

Q. In Teva documents?

A Yes.

Q. And did you see statements about dependence and that it's easy to deal with or normal, things along that line?

A Yes.

Q. Did you see such statements in Allergan Finance documents?

A Yes.

Q. In Endo documents?

A Yes.

Q. In Teva documents?

A Yes.

Q. Were all of those statements made -- strike that.

Those statements, were they false?

A False and misleading, yes.

MR. BARTLE: Your Honor, I would ask that that document be marked and we be provided copies of it.

THE COURT: That's fair.

MS. CONROY: That's fine.

THE COURT: Let's mark it now.

(WHEREUPON, Document was hereby marked

as Plaintiffs' Demo 500 in evidence.)

THE COURT: We'll see that copies are distributed at the next break.

MS. CONROY: We can make a copy now.

Q. Doctor, in your opinion, is there a relationship between false promotional messages and the increased sale of opioids?

A Yes.

Q. And what is that relationship?

MR. HERSCHLEIN: Objection, your Honor. This is footnote 8.

THE COURT: The document is right in front of me as we speak. It's the question -- I'll sustain the objection. I'm not precluding you, but if you don't have it, just look at footnote number 8 in the November 12th 2020 short form order.

MS. CONROY: Your Honor, I'm referring to promotional messages in this question.

THE COURT: Make it promotional.

Q. Is there a relationship between promotional messages and the sale of opioids?

MR. HERSCHLEIN: Your Honor --

THE COURT: I think the sales aspect of

the question is the basis of the objection, so I'll sustain it, but there's something other than sales between --

MS. CONROY: Sure.

Q. Is there a relationship between promotional messages and physicians prescribing opioids?

A Yes.

MR. HERSCHLEIN: Your Honor, the objection is there's not been a foundation laid as required by footnote 8 for the distinction between marketing and promotion. The Defendants' position is that there is no distinction.

MR. PRESNAL: With all due respect -

THE COURT: Do me a favor, put your mask down when you talk to me.

MR. PRESNAL: Sorry, Judge. With all due respect, she has examined this confluence between this massive marketing campaign and the fact that there was a massive increase in the prescribing of opioids as described it this paradigm shift in the treatment of chronic pain.

MR. KNAPP: Your Honor, again, I would object to the colloquy as inappropriate.

THE COURT: Ms. Conroy, you may seek testimony between what we've seen and quantity, all right.

Q. Doctor, have you seen a relationship between the promotional messages that you reviewed and the quantity of opioids in New York State, Long Island, or the Counties?

THE COURT: Just yes or no.

A Yes.

Q. And what is that relationship?

A The promotional messages targeting doctors and other healthcare institutions led to increased prescribing of opioids, which led to a greater supply of opioids in the community.

Q. And what did that lead to?

A That led to more people becoming addicted to opioids, more people overdosing on opioids and more people dying from opioids.

Q. And where did that take us?

A Those individuals, many of them, progressed to heroin and illicit fentanyl.

Q. And is there a term for that, that

progression to heroin or illicit fentanyl?

A Yes. It's called the gateway phenomenon or gateway hypothesis where individuals start out with pain pills prescribed by their doctor or perhaps pain pills that were prescribed to somebody else in the family, which they took from the medicine cabinet for the right reasons, and then the individual ultimately gets addicted to the opioid and then looks for cheaper and more available sources over time, which is illicit sources like heroin and illicit fentanyl.

Q. Doctor, you call that what?

A The gateway theory or the gateway phenomenon.

Q. Is that your term or do others use that as well?

A That's a term that I have used, as well as -- and others have used that term as well.

MS. CONROY: Thank you, Doctor. I have no further questions at this time.

THE COURT: Mr. Shkolnik?

MR. SHKOLNIK: Your Honor, I'm going to have about 45 minutes to an hour. Could we take our -- I could condense it if we took

our lunch break at 12:15 or 12:30, that would really help, unless the Court wants me to stop. I will be happy to do it either way.

THE COURT: That's okay. Members of the jury, are you hungry?

We'll break for lunch. We'll resume at 1:30. Don't discuss the case among yourselves or with anyone else until the appropriate time.

Thank you.

MS. CONROY: Thank you.

THE COURT OFFICER: All rise. Jury exiting.

THE COURT: See everybody at 1:30. Thank you.

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C E R T I F I C A T I O N

I, Stephanie Casagrande Hague, CSR, RPR, an Official Court Reporter of the State of New York, County of Suffolk, do hereby certify that the above is a true and accurate transcription of my stenographic notes taken in the above-entitled action on this day;

Furthermore, photocopies made of this transcript by any party cannot be certified by me to be true and accurate.

Therefore, only those copies bearing an original signature in blue ink are official certified copies.

_____
STEPHANIE CASAGRANDE HAGUE, CSR, RPR
Official Court Reporter

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